THE RECOVERY KERNEL

How to Navigate the Recovery Kernel

For People Recovering from Alcohol

A step-by-step route: what to read, in what order, and what outcome the Kernel projects if you follow it.

> **HARM REDUCTION RESOURCE — NOT MEDICAL ADVICE. ALCOHOL WITHDRAWAL CAN BE FATAL.** If you drink daily, drink in the morning to stop shaking, feel sweaty, shaky, or nauseous when you go without for several hours, or have ever had a seizure or hallucinations when stopping, do not stop abruptly. Call your doctor, go to urgent care, or contact a detox facility first.
>
> In a heavy drinker, confusion, memory problems, abnormal eye movements, or loss of coordination can signal Wernicke's encephalopathy. Go to an emergency room now.
>
> Emergency: 911 · Crisis: call or text 988 · SAMHSA: 1-800-662-4357

1. Before you start

This is a route through the Recovery Kernel for people recovering from alcohol use disorder, whether the pattern is daily heavy drinking or problem drinking without physical dependence, and for the people supporting them. Four rules set the order of everything that follows.

- **Triage before anything.** Whether you are physically dependent decides whether Step 1 is a detox facility or a physician check-in. Answer the Step 0 questions first. If you are unsure which category you are in, assume the more cautious one.
- **Medical safety before biology.** The Kernel's alcohol chapter opens with a medical warning for a reason: for anyone physically dependent, the framework begins with supervised detox, not a supplement stack. Supplements do not prevent withdrawal seizures.
- **GABA repair is the primary biological target.** In alcohol recovery it is both the most damaged system and the one whose deficit most directly drives relapse. Everything else happens inside that container (Supplemental Ch. 8 §7).
- **Do not wait for test results to start.** The genome refines the plan. It never gates the detox decision (Main Book, Quick-Start Step 3; Supp. Ch. 5, Step 1b).

How chapters are cited. "Main Book" is the Recovery Kernel Main Book (Second Edition, Centurian). "Compendium" is the Complete Protocol Compendium. "Supp. Ch. N" is chapter N of the Supplemental Book: Chapter 8 (How to Recover from Alcohol) is the core chapter. Section numbers (§) refer to sections inside it.

> **A note on protocol numbers.** Supplemental Chapter 8 cites Compendium protocols by number, and some numbers do not match the Compendium as printed. Chapter 8 calls Protocol 05 "environmental redesign," Protocol 06 "trigger mapping," Protocol 20 "identity reconstruction," and Protocol 04 "Dharma Recovery." The Compendium prints those as Digital Detox, Phenotype Assessment, Mapping the Terrain, and Meeting Alternatives. This guide cites each protocol by its printed title and number. If a number and a title disagree, follow the title.

> For alcohol, watch for “catching up” with a round, or drinking through anxiety that keeps returning — both read a normal, partial effect as failure.
>
> Redosing is not the only version of this. Watching peers in a treatment setting negotiate a relapse, getting confident advice from someone untrained in your specific situation, or noticing a prescriber treat a prescribed substance more casually than an illicit one can all trigger the same pattern: a felt doubt read as “the plan must be wrong,” answered by abandoning it. See **The Commandeering Map**, a companion to this series, for the fuller pattern, including how it can differ by genetic profile and what helps when practice-based resistance alone is not enough.

2. The route at a glance

Steps 0 and 1 come first and cannot be skipped. Steps 2 to 4 can run at the same time once you are medically stable. Steps 5 to 9 overlap and are the work of the first two years. Step 10 is everything after. "P" means Compendium Protocol; "C" means Centurian Paper.

Step	When	What you do	Turn to
0	Day 0	Triage: are you physically dependent? Know the emergency signs, including Wernicke's.	Supp. Ch. 8, opening and §3.1 Main Book, Quick-Start Step 1 Compendium P01
1	Days 0–7 (dependent use)	Supervised detox. Thiamine from the start. Never substitute supplements.	Supp. Ch. 8 §3 Supp. Ch. 9, 30, 10 if co-use
2	Weeks 1–4 (once stable)	Read the Main Book in order.	Main Book: Who This Book Is For, Quick-Start, Part One (Ch. 1–5) Supp. Ch. 2, 3, 4
3	Weeks 1–4	Order 30× whole-genome sequencing. Add a clinical PGx panel and baseline labs, including liver function.	Supp. Ch. 5 Step 1 Supp. Ch. 8 §2 Compendium P06
4	Weeks 2–6	Resolve your combined profile. Carry a prescriber card.	Supp. Ch. 5 Steps 2–3, 6 Supp. Ch. 4 Supp. Ch. 8 §2
5	Day 1 to Month 6	Build the biological foundation with your physician: nutrition, GABA, serotonin and dopamine, liver.	Supp. Ch. 8 §4 Supp. Ch. 5 Phase One Compendium P07, P09, P17, P18
6	Weeks 2–12, then ongoing	Learn the three craving types. Replace the ritual. Name transfer risks before they appear.	Supp. Ch. 8 §§3.3, 4.5 Supp. Ch. 49 Compendium P02, P20, P21, P08, P33
7	Months 1–24	Rebuild sleep and your own GABA: breath, exercise, stillness, community, service.	Supp. Ch. 8 §§5, 6 Supp. Ch. 36 Compendium P19, P03, P04, P29
8	From detox onward	Bring the medication options to your physician. Track liver and heart.	Supp. Ch. 8 §8 Supp. Ch. 38 Compendium P44, P13
9	Months 2–12+	Identity, inventory, amends, money, work, family.	Supp. Ch. 42, 43, 51 Compendium C-28, P23, P24, P22
10	Year 1 to Year 10	Steward: review, transplant, mentor.	Supp. Ch. 44, 6, 38 Compendium P02, P13 Supp. Ch. 5 Step 6

3. The route, step by step

Step 0 — Triage (Day 0, before everything)

Alcohol withdrawal is the one common withdrawal in which a documented sequence can occur without warning: anxiety, tremor, agitation, seizure, delirium tremens, death. It can begin 6 to 48 hours after the last drink in a physically dependent person. The Kernel states that delirium tremens carries a mortality rate of up to 15% without treatment.

Medical detox is required, not recommended, if any of these apply: you drink daily and have for more than two or three weeks; you have physical symptoms between drinks (shaking, sweating, racing heartbeat, nausea, anxiety that alcohol relieves); you have ever had a withdrawal seizure or delirium tremens; you also use benzodiazepines or other GABAergic substances, because combined withdrawal is especially dangerous; or you carry a GABRA2 high-risk variant, in which case tell your detox team. If none of these apply and you drink problematically without physical dependence, the rest of the framework applies more directly.

Turn to: Supp. Ch. 8, opening note and §3.1 (when medical detox is required). Main Book, Quick-Start Boot Sequence, Step 1. Supp. Ch. 5, the "Read first" box. Compendium Protocol 01, Emergency Triage, for an acute crisis state.

Step 1 — Medical detox (Days 0–7 for dependent use)

Outpatient detox suits mild to moderate dependence with a safe home environment and daily medical contact. Inpatient detox, typically 3 to 7 days with continuous monitoring, is required for severe dependence, prior seizure history, a GABRA2 high-risk profile, co-occurring medical conditions, or no safe home. A benzodiazepine taper, typically diazepam or chlordiazepoxide, is prescribed to prevent seizures while the brain recalibrates. The standard monitoring tool is the CIWA; ask your team about it, because understanding it helps you report symptoms accurately. Begin high-dose thiamine immediately to prevent Wernicke's encephalopathy.

The medical window is roughly hours 6 to 24 after the last drink, with peak risk at hours 24 to 72 (severe anxiety, confusion, possible hallucinations, seizure risk). If withdrawal symptoms start and you are not in care, call a physician, go to urgent care, or call 911. Do not manage this alone.

Turn to: Supp. Ch. 8 §3 (3.1 when detox is required, 3.2 timeline, 3.3 PAWS). If you also use benzodiazepines: Supp. Ch. 9 (Benzodiazepines) and Supp. Ch. 30 (Forced Discontinuance). If you also use GHB: Supp. Ch. 10 and Supp. Ch. 31. The supplement protocol begins after medical stabilization, not instead of it.

Step 2 — Read the Main Book (Weeks 1–4, once medically stable)

Read it in order once you are physically stable. If you are overwhelmed, the Quick-Start Boot Sequence is designed to be read on its own. Read "Who This Book Is — and Is Not — For" first: it names the situations where the supplement protocols need medical modification, including active psychosis, pregnancy, and severe liver disease, the last of which matters for many people in alcohol recovery.

Read in this order: Who This Book Is For → Quick-Start Boot Sequence → Part One: Ch. 1 (Why Willpower Isn't Enough), Ch. 2 (MTHFR), Ch. 3 (COMT; the Sage or Worrier profile is heavily represented in alcohol use), Ch. 4 (CYP450), Ch. 5 (When Systems Collide) → Ch. 7 (Harm Reduction), only if you are still drinking → Part Two, the case files (Chapter 6). Ch. 8 (Oxytocin Protocol) is experimental and specialist-only. Ch. 9 (Epigenetic Playground) belongs to Steps 7 and 10. Appendix A and Appendix B are reference.

Then add: Supp. Ch. 4 (The Braking System: GABRA2 and GABRB3), the most important supporting chapter for alcohol. Supp. Ch. 2 (Clarity · Restoration · Manning), which includes the two alcohol case studies, Case 01 and Case 12. Supp. Ch. 3 (The Addict Virgin Problem), which recalibrates timelines for a damaged system. Supp. Ch. 1 (Why They Left You There) is optional reading for the shame.

Step 3 — Get your DNA (Weeks 1–4)

The Kernel's recommended route is 30× whole-genome sequencing, which returns a VCF file, a one-time asset you keep. A consumer SNP array is an acceptable start. A clinical pharmacogenomic panel adds clinical-grade CYP calls. Homocysteine, B12, and RBC folate are functional markers you can recheck quarterly. Liver function tests belong in your baseline labs.

For alcohol, the two highest-priority genes are **GABRA2** and **OPRM1**, because they directly determine medical decisions: seizure monitoring and whether naltrexone is likely to work well for you. Next come COMT, ALDH2, ADH1B, MTHFR, DRD2/ANKK1, SLC6A4, and CYP2E1, plus GABRB3 (seizure threshold, Supp. Ch. 4). CYP2C19 and CYP2D6 matter for the medications used in recovery and for co-occurring conditions. Until results arrive, use the free phenotype self-assessments: did alcohol mainly calm you, or make you feel alive and social; is there multigenerational family history; did you flush or race more than others; did antidepressants never quite work?

> **Confirm what you are ordering.** Supp. Ch. 5 specifies 30× whole-genome sequencing with VCF output. "WGBS" more commonly names whole-genome bisulfite sequencing, a DNA-methylation assay that is not built to call variants such as MTHFR C677T. Ask the lab for a standard variant file (VCF).

Turn to: Supp. Ch. 5, Step 1 (test options; free phenotype estimates). Supp. Ch. 8 §2 (DNA testing panel for alcohol recovery; phenotyping without test results). Compendium Protocol 06, Phenotype Assessment. Main Book Ch. 2 and Ch. 3 self-assessments.

Step 4 — Resolve your combined profile (Weeks 2–6)

Most alcohol use falls into a few patterns. Anxious drinking (GABRA2 high-risk plus COMT Met/Met, the "Anxious Depressant" profile) is the most common: the drink is the off switch for a nervous system that will not quiet, and anxiety management is the central recovery target. Social-reward drinking (OPRM1 A118G, possibly a Warrior COMT) is driven by the endorphin and dopamine response, so endorphin and dopamine support are priorities. Trauma-amplified drinking (GABRA2 high-risk plus adverse childhood experiences) is the Kernel's most severe profile, and needs the biological floor built before trauma processing. Write your profile down and carry your key results on a card.

If your result is...	What changes	Source
GABRA2 high-risk	Weak inhibitory brake. Alcohol's relief is extraordinary for this genotype. More severe and prolonged PAWS. Seizure risk in withdrawal, so tell your detox team. Build alternative GABA support as a first-line priority.	Supp. Ch. 8 §2, §3
OPRM1 A118G (G carrier)	Stronger reward signal from alcohol. Strongest predictor of naltrexone response in AUD, which the Kernel says can be up to 3× better. Bring it to your physician.	Supp. Ch. 8 §§2, 8
COMT Met/Met (Sage)	Heavily represented in alcohol use. The anxious brain that cannot quiet itself. Anxiety management is the core strategy.	Supp. Ch. 8 §2; Main Book Ch. 3
COMT Val/Val (Warrior)	Drinking for dopaminergic stimulation. Needs stimulation and stakes, not only calm.	Supp. Ch. 8 §2; Ch. 5
ALDH2 *2 / ADH1B fast	ALDH2*2/*2: acetaldehyde accumulates, organ damage burden is higher, and liver testing is mandatory. NAC and liver support take on extra urgency.	Supp. Ch. 8 §§1–2
MTHFR	Alcohol depletes folate and disrupts methylation. 5-MTHF and methylcobalamin are highest priority. Avoid synthetic folic acid with any T variant.	Supp. Ch. 8 §§2, 4.1; Main Book Ch. 2
DRD2 A1 and SLC6A4 s/s	DRD2 A1: build several dopamine sources. SLC6A4 s/s: high anxiety sensitivity, so rebuild serotonin as well.	Supp. Ch. 8 §2; Ch. 5 System 5
CYP2E1, CYP2C19, CYP2D6	CYP2E1: more oxidative stress from alcohol metabolism, so antioxidant and NAC support matter. CYP2C19/2D6: affect the medications used in recovery.	Supp. Ch. 8 §2

Turn to: Supp. Ch. 5, Steps 2, 3, and 6 (gene systems, combined profiles, profile template). Supp. Ch. 4. Supp. Ch. 8 §2. Main Book Ch. 5 and Appendix A.

Step 5 — Build the biological foundation (Day 1 to Month 6)

Begin after medical stabilization. Chronic drinking produces a nutritional crisis that must be addressed first, so the sequence starts with emergency replenishment: thiamine, magnesium, a methylated B-complex, 5-MTHF, zinc, vitamin D with K2, and protein. GABA restoration, serotonin and dopamine reconstruction, and liver support follow, addressed in parallel and prioritized by your profile. The Kernel notes GABA receptor upregulation is a structural process that happens through abstinence and time. Supplements support the conditions for it. They do not replace it. The dose tables are in the chapter below. If you have known liver disease, cirrhosis, or significantly elevated liver enzymes, consult your physician before any supplement, because some are hepatotoxic in liver disease. Run every addition past a pharmacist and an interaction checker (Drugs.com or Medscape). The peptide layer in Supp. Ch. 8 §4.6 is labeled by the Kernel as research compounds needing physician discussion, so it is not a self-start step.

Turn to: Supp. Ch. 8 §4.1 (emergency nutritional replenishment), §4.2 (GABA system), §4.3 (serotonin and dopamine), §4.4 (liver support), §4.6 (peptides, physician only). Supp. Ch. 5, Phase One. Main Book Ch. 2, §2.4–2.5 (eight-week ramp). Compendium Protocol 17 (The Nightly Restoration), Protocol 18 (Eating for Restoration), Protocol 09 (The Gut-Brain Axis), Protocol 07 (Neuroplasticity), and Centurian Paper C-32 (The Insomnia Architecture).

Step 6 — Cravings, rituals, and addiction transfer (Weeks 2–12, then ongoing)

The Kernel separates three craving channels. GABA-deficit craving is anxiety-driven and the most common: the nervous system requests its most reliable alarm-silencer. Dopamine-deficit craving is flat and joyless. Endorphin-deficit craving is lonely and raw, and is often misread as craving for alcohol when it is craving for the warmth alcohol produced. Naming the type changes the response. PAWS episodes are most often triggered by stress, poor sleep, illness, grief, conflict, sugar, caffeine, and alcohol cues, and can last up to two years. They are not relapse. In early recovery avoid all alcohol, including cooking alcohol and alcohol-based mouthwash.

The evening drink was often about a signal (the day is done, rest is permitted) more than pharmacology. Replace the ritual precisely: same time, same place, different content. Name the transfer risks before they appear. The Kernel calls alcohol-to-benzodiazepine transfer the most medically dangerous addiction transfer in recovery, and notes that cannabis transfer is common for the anxious drinker.

Turn to: Supp. Ch. 8 §3.3 (PAWS), §4.5 (the three craving types and the 5-minute interrupt), §6 (what alcohol was providing; replacing the ritual). Supp. Ch. 49 (Bartender's Friend: 25 neurochemically functional mocktails). Compendium Protocol 02 (Behavioral Addictions, with its "Mask Change" caution on addiction transfer), Protocol 20 (Mapping the Terrain), Protocol 21 (Reading the Collapse), Protocol 08 (Social Environment), Protocol 33 (The Boundary Architect), Protocol 05 (Digital Detox). If you are still drinking: Supp. Ch. 46 (Respect the Environment, including drunk driving) and, for a harm-reduction approach when you are not ready for abstinence, the naltrexone-based approach described in Supp. Ch. 8 §8, with a physician.

Step 7 — Rebuild sleep and your own GABA (Months 1–24)

Alcohol did not help you sleep. It sedated you. It suppresses REM almost entirely, fragments sleep architecture, and causes rebound insomnia in the second half of the night. Insomnia is the most common cited driver of early relapse, and it is one of the most responsive targets. The vivid dreams of early recovery are REM rebound, which is healing, not a symptom to suppress.

The natural GABA architecture the Kernel prescribes: a daily contemplative practice of at least 10 minutes; vigorous aerobic exercise at least four times a week; a creative practice with genuine depth; authentic in-person community; scheduled nature exposure; and service. The Kernel calls service the most reliable source of sustained wellbeing reported by many people in long-term alcohol recovery. The goal is not to become as disinhibited as alcohol made you, but to build connection that does not require disinhibition.

Turn to: Supp. Ch. 8 §5 (rebuilding sleep) and §6 (porting the addiction; the natural GABA architecture). Supp. Ch. 36 (Roots and Reversal). Supp. Ch. 3 (timeline recalibration). Compendium Protocol 19 (The Body in Motion), Protocol 03 (Sonic Architecture), Protocol 04 (Meeting Alternatives, which includes Dharma Recovery), Protocol 29 (The Peacetime Paradox), Protocol 17.

Step 8 — Medications and medical follow-up (from detox onward)

The Kernel says alcohol use disorder has the most robust evidence base of any addiction for pharmacological treatment, and that fewer than 10% of people who could benefit receive these medications. Bring the list to your physician and ask directly: naltrexone (oral or monthly injection), acamprosate, disulfiram, GLP-1 agonists, and gabapentin. The Kernel rates the first two as strong evidence and FDA-approved, disulfiram and gabapentin as moderate, and GLP-1 agonists as emerging. Acamprosate is cleared by the kidneys, which suits a compromised liver. Gabapentin carries its own dependence risk and should have a time limit. The Kernel is explicit that this framework and medication are not in competition.

Repeat liver function tests at 1, 3, and 6 months of abstinence, and assess cardiovascular health early. The liver is highly regenerative, and significant recovery is possible even from advanced damage with sustained abstinence.

Turn to: Supp. Ch. 8 §8 (FDA-approved medications and clinical considerations; co-occurring conditions). Supp. Ch. 8 §7, the Liver and Physical Recovery row. Supp. Ch. 38 (questions to ask about medication duration). Compendium Protocol 44 (GLP-1 Receptor Agonists in Recovery), Protocol 13 (The Pharma Trap).

Step 9 — Identity and rebuilding a life (Months 2–12+, revisited later)

Alcohol use disorder is often intertwined with identity: "I am someone who drinks." Sobriety requires building a self without a substance-shaped hole in it. Full Inventory is a structured 180-day plan, and Amends to Self puts the person who lived through it first. Family, money, and work follow. If trauma is part of your history, the Kernel's Case 12 shows trauma therapy triggering relapse when the biological floor was not yet in place, so sequence it after Steps 1 to 7.

Turn to: Supp. Ch. 42 (Full Inventory). Supp. Ch. 43 (Amends to Self). Centurian Paper C-28 (The Recast). Supp. Ch. 39 (Complex Trauma and the Substance Connection). Compendium Protocol 23 (Rebuilding the Ledger), Protocol 24 (Returning to Work), Protocol 22 (The Family Field), Protocol 16 (The Isolation Spiral), Protocol 25 (The Open Door). Supp. Ch. 51 (Family & Support Network Guide): give it to the people who love you.

Step 10 — The long game (Year 1 to Year 10)

The Kernel maps the first 24 months of alcohol recovery in detail. After that, navigation shifts from repair to stewardship. Section 4 shows how. Standing tools: Supp. Ch. 44 (The Transplant: redirect the devotion and daily structure the drink required into a practice that grows). Supp. Ch. 6 (Stay Non-Addicted) and Compendium Protocol 02 (addiction transfer). Compendium Protocol 13 (The Pharma Trap, a regular review of whether each medication is still needed). Supp. Ch. 38. Supp. Ch. 5, Step 6 (a weekly AI check-in profile, a reasoning tool and never a provider).

4. How navigation changes at Years 3, 5, and 10

Shading shows how much attention each track needs. Darkest is primary focus, then active, then maintenance. White cells with gray text are standing safeguards: low effort, never dropped. Numbers in brackets refer to the shifts listed below the table.

Track	Months 0–24 (foundation)	Year 3 (consolidate)	Year 5 (build out)	Year 10 (steward)
Safety and medical	Supervised detox; thiamine from day 1	Medication review, not autopilot [1]	Never withdraw alone again	No benzodiazepine swap, no sedatives [7]
Biology and genome	GABRA2, OPRM1; B-vitamins, magnesium	Retest labs; step stack to upkeep [2]	Prescriber card: GABRA2, OPRM1	Re-check with new meds and age
Body and liver	Nutrition, LFTs; heal the gut	Liver and heart labs repeated	Annual physical and liver labs	Annual physical, cardiac check
Cues and environment	Cue removal; ritual replaced	Alcohol-free rituals hold	Triggers shift: grief, toasts [5]	Same plan, rehearsed
GABA, sleep, anxiety	Breath, magnesium, sleep; PAWS waves	Own GABA carries the load [3]	Contemplative practice daily	Practice, sleep, stress plan
Identity and inventory	Identity from month 2; sober self	Inventory; amends to self	Sober community established	Annual re-inventory
Meaning and Manning	Purpose: first seeds only	Transplant; return to work [4]	Manning: mentor, service [6]	Mentor or run a group

The seven shifts

1. **Year 3, medication becomes a review, not autopilot.** The Kernel treats medication as scaffolding with exit criteria and a regular-review standard (Compendium Protocol 13). Supp. Ch. 38 describes naltrexone as a medication with a "use for a defined period while rebuilding, then reassess" model, and Supp. Ch. 8 §8 says gabapentin should carry time limits. Bring the duration and readiness questions to your prescriber for each medication you take.
2. **Year 3, the stack moves from building to upkeep.** GABA and glutamate systems are normalized and dopamine and serotonin baselines recovered by 12 to 24 months (Supp. Ch. 8 §3.2). Retest labs (Supp. Ch. 5 Step 1a) and step down toward maintenance. The Trinity chapter says supplements are taken until stable, then tapered and resumed if the system destabilizes; Main Book Ch. 2 treats MTHFR support as maintenance, not cure. Step down to maintenance, not to zero.
3. **Year 3, your own GABA carries the load.** PAWS can last up to two years, so by year 3 the waves should be rare. Breathwork, exercise, contemplative practice, and community stop being emergency tools and become ordinary life. The Kernel notes measurable brain volume restoration in the second year of sobriety (Supp. Ch. 8 §3.2, §7).

4. **Year 3, meaning moves up.** As the repair tracks drop to maintenance, redirect the devotion and daily structure the drink required into a practice (Supp. Ch. 44) and return to work (Compendium Protocol 24).
5. **Year 5, triggers shift from cues to life events.** As cue-driven craving fades, the remaining exposure is the triggers the Kernel names for PAWS, such as grief, conflict, illness, and stress, plus celebrations where drinking is expected. Transfer risks stay live: alcohol-to-benzodiazepine, and cannabis for the anxious drinker (Compendium Protocol 02). Keep Protocol 21 ready.
6. **Year 5, Manning.** This is the Trinity's third stage (Supp. Ch. 2). Supp. Ch. 8 §6 reports that service is the most reliable source of sustained wellbeing for many people in long-term alcohol recovery, so mentoring and peer support peak here.
7. **Year 10, GABAergic substances stay off the table, and you never withdraw alone again.** The Kernel identifies alcohol-to-benzodiazepine transfer as the most medically dangerous transfer, and GABRA2 high-risk carriers as a "Hard Fail" profile for combining alcohol with GABAergic agents. A return to daily drinking is a return to the withdrawal emergency: it needs supervised detox, not a solo stop.

What is sourced and what is extrapolated. *Shifts 3, 6, and 7 rest directly on Kernel text. Shifts 1 and 2 apply Kernel rules at a timing chosen for this guide. Shifts 4 and 5 are extrapolations, with 5 partly sourced. The Kernel's detailed alcohol timeline ends near month 24, and its WHEN Correlator puts deep-root reversal at 2 to 5 or more years. Years 3, 5, and 10 are therefore projections.*

5. What outcome to expect

The short version

If you do the route above, with triage and supervised detox first, the nutritional and GABA foundation after that, cravings and rituals handled deliberately, sleep and your own GABA rebuilt, medication options used, and then identity and purpose work, this is the outcome the Kernel projects:

- **You get through the medical window** with no unsupervised stop at a dependent level, thiamine from the start, and a benzodiazepine taper managed by a team.
- **Within the first six months, sobriety starts to feel like something rather than the absence of something.** Anxiety measurably reduces, sleep becomes restorative, cravings shorten week by week, and the liver begins to heal.
- **By 12 to 24 months the brain and liver are substantially restored.** GABA and glutamate systems normalize, dopamine and serotonin baselines recover, brain volume loss reverses in measurable ways, and cravings are contextual rather than constant. PAWS can run up to two years.
- **By years 3 to 5 the work is maintenance and building. By year 10 you are a steward,** carrying a small set of standing safeguards.

The Kernel does not promise zero risk or that a return to drinking cannot happen. It states that alcohol withdrawal can kill, that PAWS can last up to two years, and that the timeline is biological, not motivational.

Milestones, in order

Milestone	When	Expected outcome	Source	Basis
Get through the medical window	Days 0–7 (dependent use)	Supervised detox with a benzodiazepine taper and thiamine. No unsupervised stop. Seizure and delirium tremens risk managed.	Supp. Ch. 8 §3	Clinical fact
Acute risk passes	Days 3–7	Fatigue, emotional rawness, sleep disruption, depression, and strong cravings. Foundation and nutrition begin.	Supp. Ch. 8 §3.2	Clinical timeline
The rebuilding	Weeks 1–4	Cravings come in waves, not continuously. PAWS episodes likely. Exercise begins as the repair signal.	Supp. Ch. 8 §3.2	Kernel projection
Sobriety feels like something	Months 1–6	GABA receptors recovering. Sleep normalizing. Cognitive clarity returning. Liver improving on repeat tests at 1, 3, and 6 months.	Supp. Ch. 8 §3.2, §7	Kernel projection
PAWS window	Up to 2 years	Waves of anxiety, low mood, insomnia, or craving triggered by stress, poor sleep, illness, grief, or conflict. Not relapse.	Supp. Ch. 8 §3.3	Kernel projection
Brain and liver recovery	Months 6–24+	Brain volume substantially restored. GABA and glutamate normalized. Liver largely restored in most without cirrhosis. Cravings contextual.	Supp. Ch. 8 §3.2	Kernel projection
Deep-root reversal	2–5+ years	Prefrontal recovery and epigenetic reversal continue. Some changes may be partial.	Supp. Ch. 36	Kernel projection
Steward phase	Years 3–10	Repair tracks at maintenance. Purpose and service. Standing safeguards.	Section 4 of this guide	Extrapolated

The Kernel's own 12-month numbers for two alcohol profiles

Supplemental Chapter 2 gives projected outcomes at 12 months for an adherent protocol compared with standard treatment. Case 01 is a 38-year-old healthcare worker whose two glasses of wine at 5 pm became a bottle, who has tried AA three times, and who has a COMT Met/Met profile. Case 12 is a 44-year-old with an ACE score of 8 out of 10, a first drink at 13 that felt like a siren turning off, and trauma therapy that had triggered relapse each time. She has a GABRA2 high-risk profile compounded by developmental adversity.

Case	Measure	Kernel protocol	Standard treatment
Case 01	Sustained abstinence or moderation at 12 months	72%	25%
Case 01	Anxiety reduction of 50% or more at Month 6	80%	30%
Case 01	Sleep normalization without chemical assistance	75%	20%

Case	Measure	Kernel protocol	Standard treatment
Case 01	Craving intensity reduction of 60% or more at Month 6	70%	20%
Case 12	12-month sustained reduction or abstinence with medical support	58%	12%
Case 12	Trauma therapy engagement without relapse at Month 6	62%	15%
Case 12	Significant PTSD or anxiety symptom reduction at Month 6	65%	10%
Case 12	No ER visit or hospitalization at 12 months	73%	40%

How to read these numbers. *The Kernel describes them as archetype projections, "probability estimates" for an adherent, biologically confirmed 12-month protocol, drawn from cited studies and SAMHSA and NIDA baselines. They are not guarantees, and the Main Book states that it is not reporting a randomized controlled trial of the Kernel itself. Two details matter. Case 01's headline figure counts abstinence or medically supervised moderation, not abstinence alone. And Case 12 carries the Kernel's own caution: month 12 is not complete recovery, but the beginning of stable architecture from which the real rebuilding can hold.*

What changes the outcome

- **Stopping abruptly after physical dependence without medical care.** Withdrawal can cause seizure and delirium tremens.
- **Treating supplements as a substitute for detox.** The Kernel is explicit that supplements do not prevent withdrawal seizures.
- **Missing Wernicke's warning signs.** Confusion, memory problems, abnormal eye movements, or loss of coordination in a heavy drinker is an emergency-room visit, not a supplement question.
- **Transferring to benzodiazepines or other sedatives.** Alcohol-to-benzodiazepine is the most medically dangerous transfer. The Kernel also advises against phenibut, which it calls addictive.
- **Poor sleep.** Insomnia is the most commonly cited driver of early relapse.
- **Hidden alcohol.** Even trace amounts, in cooking alcohol or mouthwash, can activate the reward circuit in early recovery.
- **Starting trauma processing before the biological floor exists.** Case 12 is the Kernel's example.
- **Isolation.** Cravings execute in isolation. Make one contact when they arise.
- **Expecting a short timeline.** PAWS can run up to two years, and the timeline is biological, not motivational.
- **A lapse.** The Kernel treats it as information, not judgment (Protocol 21). If it becomes daily drinking again, go back to supervised detox rather than stopping on your own.

How to read the evidence behind the outcomes

The Main Book marks claims with an Evidence Tier: Established, Probable, Emerging, Author/System Experience, and Controversial or Mixed. This guide's reading: the danger of alcohol withdrawal and the value of supervised detox are well-established clinical facts. The Kernel itself rates naltrexone and acamprosate as strong evidence and FDA-approved, disulfiram and gabapentin as moderate, and GLP-1 agonists as emerging. The supplement stack, the natural-GABA claims, the peptide layer, the percentage projections, and the years 3 to 10 trajectory sit lower on that scale, so bring them to your clinician as questions, not as facts. The peptide layer is labeled as needing physician discussion.

Take these to your clinician

- A complete and honest drinking history: how much, how often, how long, whether you drink in the morning, and any prior withdrawal seizure or delirium tremens. Include any benzodiazepine or other sedative use.
- Your GABRA2 and OPRM1 results (they change seizure monitoring and naltrexone appropriateness), plus any ALDH2, COMT, MTHFR, and CYP results.
- Baseline liver function tests, and a request to repeat them at 1, 3, and 6 months, plus an early cardiovascular assessment.
- A direct question about naltrexone, acamprosate, disulfiram, GLP-1 agonists, and gabapentin, including how long each would be used and what marks readiness to review it.
- Every supplement you take, with doses, so interactions can be checked. Some are contraindicated in liver disease.